State of Idaho DEPARTMENT OF INSURANCE

SUSPECT FRAUDULENT CLAIM REPORT

DATE:

REPORTING PERSON INFORMATION								
YOUR NAME:	E-MAIL:							
STREET ADDRESS:	PHONE:							
THEET ADDRESS.	THORE.							
CITY: STATE:								
CIII.		JIAIL.	ZIP:		_			
CASE DETAILS								
INSURANCE COMPANY:	*NAIC # (optional):							
*CLAIM # (optional):				*POLICY # (optional):				
LOCATION OF LOSS:								
STREET ADDRESS:	PHONE:							
CITY:		STATE:	ZIP:		DATE OF LOSS:			
TYPE OF CLAIM:								
☐ Agent	☐ Auto		Commercial Liability		☐ Disability			
☐ Health	☐ Homeowner/Rental			Life	☐ Mortgage			
☐ Property & Casualty ☐ Worker's Comp				Other				
INSURED INFORMATION (policyholder)								
					MI:			
LAST:				1;	MI.			
CTREET ADDRESS	BUOVE							
STREET ADDRESS:	PHONE:							
CITY:		STATE:	ZIP:		E-MAIL:			
If there is more than one insured, please include the information in Reason for Referral section below.								
CLAIMANT INFORMATION								
LAST:			FIRST:		MI:			
STREET ADDRESS:					PHONE:			

CITY:	STATE:	ZIP:	E-MAIL:				
If there is more than one claimant, please include the information in Reason for Referral section below.							
WITNESS INFORMATION							
LAST:		FIRST:	MI:				
STREET ADDRESS:		PHONE:					
CITY:	STATE:	ZIP:	E-MAIL:				
OTHER (agent, physician, chiropractor, pharmacist etc.)							
LAST:		FIRST:	MI:				
			211211				
STREET ADDRESS:		PHONE:					
CITY:	STATE:	ZIP:	E-MAIL:				
CITT.	STATE:	ZIP:	E-MAIL:				
If there is more than one witness, pla	ease include the info	mation in Reason for Referral sec	tion below				
If there is more than one witness, please include the information in Reason for Referral section below. REASON FOR REFERRAL							
NEXT OF THE ENTRE							